

**COASTAL FOOT AND ANKLE CLINIC  
WELCOME**

**PATIENT INFORMATION**

DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

CITY STATE ZIP

HOME PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

SEX: M \_ F \_ AGE \_ BIRTHDATE \_\_\_\_\_

MARITAL STATUS:  
\_ SINGLE \_ MARRIED \_ WIDOWED \_ SEPARATED  
\_ DIVORCED

PATIENT SS# \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER PHONE: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SS# \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_

**PHONE NUMBERS**

BEST TIME AND PLACE TO REACH YOU? \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

IN CASE OF EMEGENCY, CONTACT:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

**INSURANCE**

WHO WILL BE RESPONSIBLE FOR THE CHARGES ON THIS ACCOUNT? \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to DR. Marsh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

**CONSENT**

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Marsh to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremity.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to DR. MARSH for any services furnished me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**MEDICAL RECORDS RELEASE POLICY**

The original medical records/x-rays contained in Dr. Marsh's patient charts will not be released from these premises under any circumstances.

Patient Signature \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

**THIS OFFICE HAS A "NO TOLERANCE" DRUG POLICY. DR MARSH RARELY WRITES PRESCRIPTIONS FOR NARCOTICS.**